Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	009551	A. BUILDING: _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME HEALTH AND HOSPICE	1900 CAREW ST STE 6 FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a hospice state licensure survey Survey dates: March 19, 20, and 21, 2013 Facility Number: 009551 Medicaid Number: 200160160 Surveyor: Miriam Bennett, RN, BSN, PHNS Parkview Home Health and Hospice is in compliance with the Indiana rules for hospice IC 16-25-3 and the Conditions of Participation 42 CFR Part 418. Quality Review: Joyce Elder, MSN, BSN, RN March 22, 2013	S 000		